**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

TEXAS HEALTH OF DALLAS
3255 W PIONEER PKWY
ARLINGTON TX 76013-4620

**Respondent Name**
TPCIGA for Credit General Indemnity

**Carrier's Austin Representative Box**
Box Number 50

**MFDR Tracking Number**
M4-12-1874-01

**MFDR Date Received**
January 31, 2012

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Medicare would have allowed this facility $1,507.82 for the MAR at 200%. Based on their payment of $1,439.06, a supplemental payment of $68.76 is due."

**Amount in Dispute:** $68.76

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The requestor has not submitted the data they are using for each piece of the formula. Therefore, we are unable to further research the difference in our recommendation and the amounts provided by the requestor."

**Response Submitted by:** Texas Property & Casualty Insurance Guaranty Association

## *SUMMARY OF FINDINGS*

| Date(s) of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| September 13, 2011 | Outpatient Hospital Services | $68.76 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 21, 2011
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/ROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.

- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.

Explanation of benefits dated December 15, 2011

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W1 – Workers Compensation State Fee Schedule Adjustment.

**Issues**

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

**Findings**

1. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code 78102 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0400, which, per OPPS Addendum A, has a payment rate of $257.02. This amount multiplied by 60% yields an unadjusted labor-related amount of $154.21. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of $149.83. The non-labor related portion is 40% of the APC rate or $102.81. The sum of the labor and non-labor related amounts is $252.64. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $252.64. This amount multiplied by 200% yields a MAR of $505.28.
   - Procedure code 78805, date of service September 14, 2011, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0414, which, per OPPS Addendum A, has a payment rate of $474.98. This amount multiplied by 60% yields an unadjusted labor-related amount of $284.99. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of $276.90. The non-labor related portion is 40% of the APC rate or $189.99. The sum of the labor and non-labor related amounts is $466.89. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $466.89. This amount multiplied by 200% yields a MAR of $933.78.
   - Procedure code A9521 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code A9541 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
3. The total allowable reimbursement for the services in dispute is $1,439.06. This amount less the amount previously paid by the insurance carrier of $1,439.06 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | May 9, 2013 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.